MEDPAC Medicare Payment Advisory Commission

NEWS RELEASE

Contact: Mark E. Miller
(202) 220-3700

MEDICARE PAYMENT ADVISORY COMMISSION RELEASES REPORT ON MEDICARE PAYMENT POLICY

Washington, DC, June 15, 2004 — Today, the Medicare Payment Advisory Commission (MedPAC) releases its June 2004 *Report to the Congress: New approaches in Medicare*.

In the report MedPAC begins to look at two provisions of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA)—the prescription drug benefit and chronic care. The report examines how formulary systems are established and maintained, including defining therapeutic categories, operating pharmacy and therapeutics committees, and designing the appeals process. It also examines the issues arising when drug plans enter or exit markets or beneficiaries switch plans, including arranging the prior approval of off-formulary drugs and informing physicians, pharmacists, and beneficiaries of changes in formularies, cost sharing, and other procedures.

In the MMA, the Congress also established the Chronic Care Improvement Program. The program will test different models of care coordination as well as whether care coordination reduces program spending. The Commission has expressed a strong interest in assuring physician involvement in the initiative and in improving coordination of care for Medicare beneficiaries to improve quality.

The report also considers two long standing issues in Medicare: the characteristics and spending patterns of those beneficiaries who have coverage under both Medicare and Medicaid (the dual eligibles) and the health care purchasing strategies the private sector uses that might be useful for Medicare. Dual eligibles tend to be poor, report lower health status than other beneficiaries, and cost Medicare about 60 percent more than nondual eligibles. Nevertheless, the report finds a diverse population, with spending concentrated among a minority of dual eligibles and a significant portion reporting good health and few physical and cognitive limitations. It also finds that current policies create incentives to shift costs between payers, hinder efforts to improve quality and coordinate care, and may reduce access to care.

The report finds that other purchasers are taking steps to increase the value of their healthcare spending: measuring and reporting resource use and quality to providers, encouraging beneficiaries to make more cost-conscious health care decisions, using hospitalists, and aligning financial incentives across settings. For imaging services, purchasers are using additional strategies, including enforcing safety standards for imaging equipment, limiting the type of providers qualified to deliver a service, and reviewing appropriateness of claims.

Evaluating the feasibility and value of particular strategies for Medicare FFS, will require consideration of the program's ability to administer these strategies effectively and the potential impact on beneficiaries and the health care delivery system.

In addition, the report examines two of the fastest growing sectors of the Medicare program, long term care hospitals (LTCHs) and hospice care. LTCHs' current role is to provide post-acute care to a small number of medically complex patients. The report finds the supply of LTCHs is a strong predictor of their use, acute hospitals and skilled nursing facilities are the principal alternatives to LTCHs, and LTCH patients usually cost Medicare more than similar patients using alternative settings—except for patients of the highest severity. The Commission recommends that long-term care hospitals and their care be defined by facility- and patient-level criteria that better differentiate their product and the characteristics of the patients that will benefit the most from their care.

The hospice payment system has not been changed since the benefit was established in 1983. A re-examination of the services hospices provide could help efforts to refine payments both to reflect factors affecting costs (such as case-mix, length of hospice enrollment, care settings, and geographic variation) and to ensure quality of care. Better data could also help in examining hospice eligibility requirements and in revising Medicare payments to Medicare Advantage plans to encourage plans to continue care coordination activities for members who elect hospice care.

Information technology (IT) in health care settings is important to Medicare because of its potential to improve the quality, safety and efficiency of health care. Quality and process improvements motivate investment for many organizations, yet diffusion of clinical IT in health care is generally low. Investment may be discouraged by both the complexity of acquiring and implementing major IT systems and by the health care market, where care delivery is fragmented and payment policies reward volume rather than quality. Additional steps to promote clinical IT use could include financial incentives (e.g., payment policy or loans) and expanded efforts to enhance interoperability. However, any policy to stimulate further investment must be carefully considered because of uncertain returns.

The report also discusses the HHS Secretary's estimate of the payment update for physician services. Finally, it describes Medicare beneficiaries' financial resources and liability for health care costs—important determinants of access to care.

# # #

The Medicare Payment Advisory Commission is an independent Congressional advisory body charged with providing policy advice and technical assistance concerning the Medicare program and other aspects of the health care system. Its 17 commissioners represent diverse points of view and expertise.